EOHHS Medicaid Infrastructure Incentive Program:

Attachment L 2: Requirements for Medicaid Managed Care Organizations and Certified Accountable Entities

Rhode Island Executive Office of Health and Human Services

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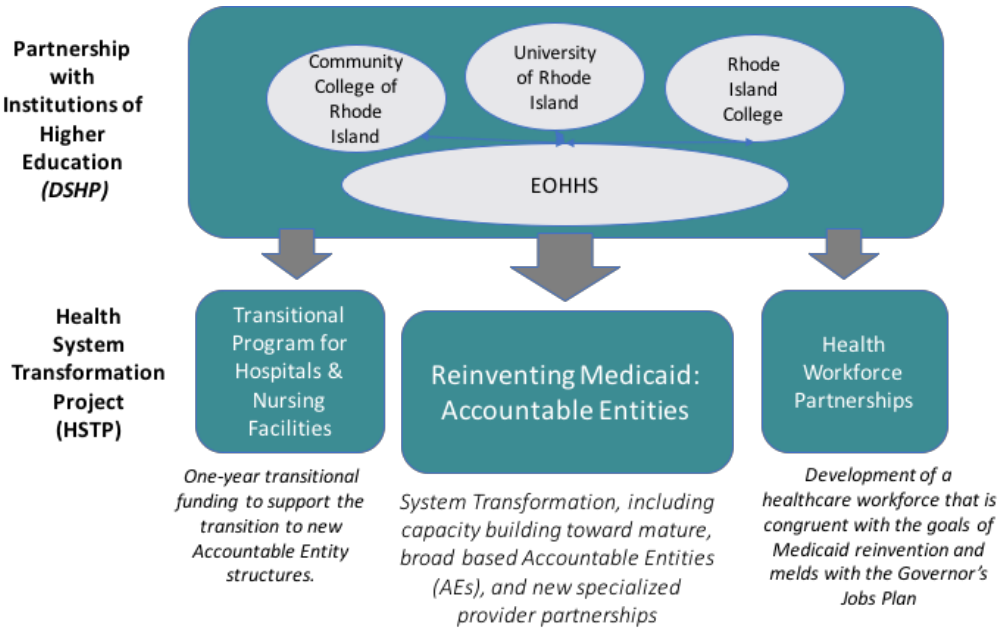
EOHHS Incentive Program Requirements

I. Background and Context

Beginning in late 2015, the Rhode Island (RI) Executive Office of Health and Human Services (EOHHS) began pursuing Medicaid waiver financing to provide support for Accountable Entities (AEs) by creating a pool of funds primarily focused on assisting in the design, development and implementation of the infrastructure needed to support Accountable Entities. RI submitted an application for such funding in early 2016 as an amendment to RI's current Global Medicaid 1115 Waiver. In October 2016, the Centers for Medicare & Medicaid Services (CMS) approved this waiver amendment, bringing $129.8 million in Federal Financial Participation (FFP) to RI from November 2016 through December 2020.[1]

This funding is based on the establishment of an innovative Health Workforce Partnership with RI's three public institutions of higher education (IHE): University of Rhode Island (URI), Rhode Island College (RIC), and the Community College of Rhode Island (CCRI), as illustrated below.

Health System Transformation Project



The majority of the financing from this waiver amendment will be provided to AEs as incentive-based infrastructure funding via the state's managed care contracts. Other CMS supported components include:

[1] The current Rhode Island 1115 Waiver is a 5-year demonstration, ending 12/31/2018. The STCs include DSHP funding authority through 2018, with a commitment articulated in the cover letter to extend this authority thru 2020 upon waiver renewal for a total funding opportunity of $129 Million.

- Investments in partnerships with Institutions of Higher Education (IHEs) for statewide health workforce development and technical assistance to AEs
- One-time funding to support hospitals and nursing facilities with the transition to new AE structures[2]
- Project management support to ensure effective and timely design, development and implementation of this program
- Project demonstration pilots and project evaluation funding to support continuous program learning, advancement and refinement
- Other supporting programs, including Consumer Assistance, Wavemaker Fellowship, TB Clinic, RI Child Audiology Center, and Center for Acute Infectious Disease Epidemiology

As mentioned above, the current RI 1115 Waiver expires December 31, 2018. The Special Terms and Conditions (STCs) of the waiver amendment include expenditure authority for this program of up to $79.9 million FFP through the end date of the current waiver.

II. Medicaid Infrastructure Incentive Program (MIIP)

Over the course of program years 1 through 4 EOHHS projects it will allocate an estimated $95 million to the AE program through the Medicaid Infrastructure Incentive Program (MIIP), as shown below. This allocation is subject to available funds captured in accordance with CMS approved claiming protocols, and annual EOHHS review and approval. This program shall begin no earlier than January 2018 and shall be aligned with the state fiscal years as shown below. Note that Program Year 1 is an extended performance period to allow for differential start dates; as such it must begin no earlier than January 1, 2018 and no later than July 1, 2018 and must end on June 30, 2019.

	Program Year 1 SFY 2018-19 *Jan 2018-Jun2019*	Program Year 2 SFY 2020 *Jul 2019- Jun 2020*	Program Year 3 SFY 2021 *Jul 2020-Jun 2021*	Program Year 4 SFY 2022 *Jul 2021-Jun 2022*	Total
Medicaid Infrastructure Incentive Program (MIIP)	$30 M	$30 M	$20 M	$15 M	$95 M

An AE Program Advisory Committee shall be established by EOHHS.

This committee shall be chaired by EOHHS, with a community Co-Chair and shall include representation from participating managed care organizations (MCOs), AEs, and community stakeholders and shall:

- Support the development of AE infrastructure priorities
- Help target Medicaid Infrastructure Incentive Program funds to specific priorities that maximize impact
- Review specific uses of funds by each AE and MCO, such that individual AE Project plans are designed and implemented to maximum effect

[2] The STCs limit this program to be one-time only and to not exceed $20.5 million, paid on or before December 31, 2017.

- Support effective program evaluation and integrated learnings
- Identify effective ways to leverage the intersection between AE project plans and workforce development partnerships

The MIIP shall consist of three core programs:

(1) Comprehensive AE Program; (2) Specialized LTSS AE Pilot Program; and (3) Specialized Pre-eligibles AE Pilot Program. EOHHS shall allocate available HSTP funds to these three programs as follows, subject to available funds and EOHHS identification of priority areas of focus and assessment of readiness. This allocation shall be revisited annually.

AE Programs	Program Year 1		Full Program
	$	%	
Comprehensive AE Program	$21 M	65-70%*	60% - 70%
Specialized LTSS Pilot AE Program	$9 M	30-35%*	25% - 35%
Specialized Pre-eligibles Pilot AE Program**	$0 M	0%	5%-15%
Total Funds	$30 M	100%	100%

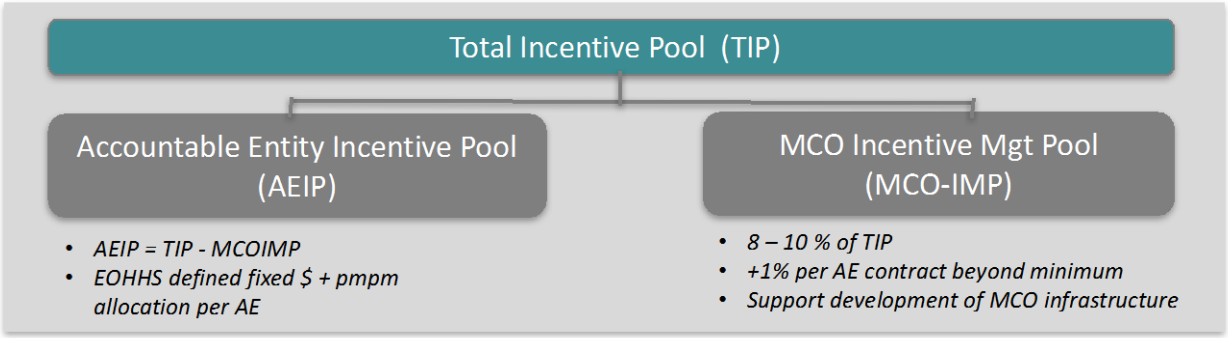
*For the purposes of illustration, PY 1 assumes a 70/30 distribution of funds between the Comprehensive AE Program and the Specialized LTSS AE Pilot Program

**Authority for this program is dependent upon CMS approval under the RI Medicaid 1115 waiver renewal, to be submitted to CMS in December 2017, effective 1/1/2019.

AEs participating in both the Comprehensive AE Program and Specialized LTSS Pilot AE Program will be eligible to receive funding from both incentive pools.

III. Determining Maximum Incentive Pool Funds

The MIIP shall include three dimensions:



Maximum Total Incentive Pool (TIP)

The maximum Total Incentive Pool (TIP) is provided in the table below. This TIP shall be allocated to each MCO by EOHHS with consideration of the MCO share of AE attributed lives in accordance with EOHHS defined attribution guidelines and associated reports.

1. MCO Incentive Management Pool (MCO-IMP)
   Assuming satisfactory MCO performance, the MCO Incentive Management Pool that can be

earned by the MCO shall be eight percent (8%) of the Total Incentive Pool. However, to the degree that the MCO has more than the minimally required number of contracts with AEs, the maximum MCO-IMP shall be increased by one percent for each AE contract to a maximum of ten percent (10%). These funds are intended for use toward advancing program success, including program administration and oversight, assisting with the development of the necessary infrastructure to support a new business model, and establishing shared responsibilities, information requirements and reporting between EOHHS, the MCO and the Accountable Entities.

2. Accountable Entity Incentive Pool (AEIP)
   The Accountable Entity Incentive Pool shall equal the Total Incentive Pool minus the maximum MCO Incentive Program Management Pool (AEIP =TIP – MCO-IMP). This shall determine the total annual amount and schedule of incentive payments each participating AE may be eligible to receive from the Accountable Entity Incentive Pool.

   Consistent with this structure, Program Year 1 MIIP funds shall be allocated as follows,

MIIP Funds **Program Year 1** *Jan 2018-Jun2019*	Accountable Entity Incentive Pool (AEIP)	MCO Incentive Management Pool (MCO-IMP)	Total Incentive Pool (TIP)
Comprehensive AE Program	$18.9 M	$ 2.1 M	**$21.0 M**
Specialized LTSS Pilot Program	$8.1 M	$0.9 M	**$9.0 M**
Total Funds	**$27.0 M**	**$3.0 M**	**$30.0 M**
% Total	*90%*	*10%*	*100%*

   subject to available funds:

AE-Specific Incentive Pools

Certified AEs in qualified Alternative Payment Methodology (APM) contracts consistent with EOHHS requirements must be eligible to participate in the Medicaid Infrastructure Incentive Program. Each MCO must create an AE-Specific Incentive Pool for each Certified AE to establish the total incentive dollars that may be earned by each AE during the period.

For Program Year 1, this AE Specific Incentive Pool shall be calculated by the MCOs as follows:

- Comprehensive AE- Specific Incentive Pools shall be the sum of two pieces (a) an incentive pool amount derived from a per member per month (PMPM) times the number of attributed lives in accordance with the following formula, plus (b) a fixed-amount base incentive pool per AE.

Estimated PMPM*	x Attributed Lives	x 12	+ Estimated Base Incentive Pool*
$8.00	At the start of each Program Year in accordance with EOHHS defined requirements	Translate to Member Month	$750,000 Fixed Amount per AE

*Note that the PMPM and base incentive pool are dependent upon the number of Certified AEs and the total attributed lives in the AE program. As such, these amounts are only estimates, and shall be finalized by EOHHS within 30 days of AE Certification.

- The Specialized LTSS Pilot AE-Specific Incentive Pool shall be determined on a per AE basis, in accordance with the formula below. The pool funding depends upon the number of Certified participating LTSS Pilot AEs as follows. This pool structure shall be finalized by EOHHS within 30 days of AE Certification. If there are fewer than four (4) certified AEs, the funds per AE remain unchanged, and any unallocated funds will be retained for future Specialized AE program use.

# Certified LTSS AEs	Program Year 1 Total $ Per Certified LTSS AE
2	$2.0 M
3	$2.0 M
4	$2.0 M
5	$1.6 M
6	$1.4 M

Note that the Specialized LTSS Program is a pilot, and as such is intended to both enhance core capabilities and provide a basis for testing the validity of the APM model. As such, 20% of the AE Specific Incentive Pool shall be set aside to support the potential shared savings associated with each AE's Total Cost of Care target, inclusive of the required quality multiplier, in accordance with state defined APM requirements, as specified in Section F of this document.

IV. AE Specific Health System Transformation Project Plans (HSTP Plans)

Under the terms of Rhode Island's agreement with the federal government, this is not a grant program. AEs must earn payments by meeting metrics defined by EOHHS and its managed care partners, and approved by CMS to secure full funding.

Certified AEs and MCOs must jointly develop individual Health System Transformation Project Plans (HSTP Plans) that identify clear project objectives and specify the activities and timelines for achieving the proposed objectives. Actual AEIP incentive payment amounts to AEs will be based on demonstrated AE performance, accordingly, incentive payments actually earned by the AE may be less than the amount they are potentially eligible to earn. MCOs shall not be entitled to any portion of funds from the Accountable Entity Incentive Pool that are not earned by the AE. Any monies not remitted to an AE from the Accountable Entity Incentive Pool must be returned to EOHHS.

Specifications Regarding Allowable AE Specific HSTP Project Plans

Approvable HSTP Project Plans must specify:

- Core Goals
  Approvable project plans must demonstrate how the project will advance the core goals of

the Health System Transformation Project and identify clear objectives and steps for achieving the goals.

- Data Driven Identification of Shared MCO/AE Priorities
  Plan must identify a set of shared MCO/AE priorities based on population specific analysis of service needs, capabilities and key performance indicators. To inform this work the MCO shall provide a population specific analysis of the AE's attributed population. The data driven assessment may provide a basis for risk segmentation of the population served by the AE that can help guide project plans. Data analyses may identify patterns of gaps in coordinated care for population subgroups such as adults with co-occurring medical and behavioral health needs and/or may identify avoidable inpatient or emergency department utilization in specific geographic areas. Project plans then focus on tangible projects within the certification domain areas, such as IT capability to identify and track needs or strengthen targeted care management or patient engagement processes. This provides for the linkage between recognized areas of need/opportunity and developmental tasks. Shared priorities must be developed through a joint MCO/AE working group that includes clinical leadership from both the MCO and the AE[3] and using a data driven approach to consider issues such as:
  - EOHHS priorities, as defined in Section D
  - Data driven assessment of the specific needs of the population served by the AE
  - The service profile of the AE (current and proposed)
  - Specific gaps in AE capacities and capabilities as defined in the AE Certification Application
  - Key Performance gaps, in quality and outcomes, relative to the populations served
  - Areas of potential enhancement of workforce skill sets to better enable system transformation
- AE Specific Core Projects: Workplan and Budget
  The AE must develop a multi-year workplan and budget to address these priorities over the course of the program (Program Year 1-4). A more detailed workplan and budget must be developed for Program Year 1 that identifies a requested set of core projects in the pertinent Domains needed to address the Shared MCO/AE Priorities. Workplan objectives for Program Years 2-4 would be at a higher level with increased refinement for the subsequent periods. To avoid duplication of funds, each core project must be MCO specific, and must specify the requested Areas of Expenditure consistent with requirements in Section E.
- Performance Areas and Milestones
  Approvable project plans must set milestones and deadlines for the meeting of metrics associated with each of the Core Projects to ensure timely performance, consistent with requirements in Section F.

MCO Review Committee Guidelines for Evaluation

The MCO shall convene a review committee to evaluate the Detailed Workplan and Budget

[3] Note: Membership in this Working Group shall be specified in the AE application, as a condition of certification.

described above. EOHHS shall have a designee that participates on the MCO evaluation committee to ensure the state's engagement in the evaluation of the project plan and associated recommendations for approval or disapproval. The MCO Review Committee, in accordance with EOHHS guidelines, shall determine whether:

- Core Projects as submitted are eligible for award
  Eligible core projects will include a workplan that clearly addresses EOHHS priority areas and includes the types of activities targeted for funds.
- Core Projects that merit Incentive Funding
  Projects must show appropriateness for this program by including the following:
  - Clear statement of understanding of the intent of incentive dollars
  - Rationale for this incentive opportunity, including a clear description of the objective for the project and how achieving that objective will promote health system transformation for that AE
  - Confirmation that the project does not supplant funding from any other source and that project funding is non-duplicative of any submissions made to another MCO
  - The inclusion of a gap analysis and an explanation of how the workplan and associated incentive plan and budget address these gaps
  - Clear interim and final project milestones and projected impacts, as well as criteria for recognizing achievement of these milestones and quantifying these impacts
- Incentive Funding request is reasonable and appropriate
  The funding request must be reasonable for the project identified, with funds clearly dedicated to this project. The level and apportionment of the incentive funding request must be commensurate with value and level of effort required.

At the discretion of the EOHHS designee, the designee may refer the proposed project for EOHHS review and approval prior to development of the subcontract between the MCO and the AE.

Development of the proposed project plan and its acceptance by the MCO Review Committee shall be considered a Performance Milestone of the HSTP Program, as specified in Section F.

Required Structure for Implementation

The Incentive Funding Request must be awarded to the AE via a Contract Amendment between the MCO and the AE. The Contract Amendment shall:

- Be subject to EOHHS review and approval
- Incorporate the central elements of the approved AE submission, including:
  - Stipulation of program objective
  - Scope of activity to achieve (may be incorporated via reference to separate project plan)
  - Performance schedule and performance metrics
  - Payment terms – basis for earning incentive payment(s) commensurate with the value and level of effort required.

- Define a review process and timeline to evaluate progress and determine whether AE performance warrants incentive payments. The MCO must certify that an AE has met its approved metrics as a condition for the release of associated Health System Transformation Project funds to the AE.
- Minimally require that AEs submit semi-annual reports to the MCO using a standard reporting form to document progress in meeting quality and cost objectives that would entitle the AE to qualify to receive Health System Transformation Project payments; such reports will be provided to EOHHS by the MCO.[4]
- Stipulate that the AE earn payments through demonstrated performance. The AE's failure to fully meet a performance metric under its AE Health System Transformation Project Plan within the timeframe specified will result in forfeiture of the associated incentive payment (i.e. there will be no payment for partial fulfillment).
- Provide a process by which an AE that fails to meet a performance metric in a timely manner (thereby forfeiting the associated Health System Transformation Project Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric.

Reconciliation

In advance of the MCOs payments to AEs, the MCO shall receive payment from EOHHS in the amount and schedule agreed upon with EOHHS. MCOs shall make associated payments to AEs within thirty (30) calendar days of receipt of payment. The MCO will maintain a report of funds received and disbursed by transaction in a format and in the level of detail specified by EOHHS. Within fifteen days after the end of each calendar quarter, the MCO will provide the report to EOHHS for reconciliation. The MCO will work with EOHHS to resolve any discrepancies within fifteen calendar days of notification of such discrepancy. Any Incentive Program funds that are not earned by EOHHS Certified AEs as planned will be returned to EOHHS within thirty days of such request by EOHHS. An AE's failure to fully meet a performance metric within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment). An AE that fails to meet a performance metric in a timely fashion can earn the incentive payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric.

Project Plan Modifications

Subcontracts between the AE and the MCO associated with AE-specific HSTP Project Plans may only be modified with state approval. EOHHS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved.

[4] Reporting templates will be developed in partnership with EOHHS

V. EOHHS Priorities

Each MCO's AE Incentive Pool budget and actual spending must align with the priorities of EOHHS as developed with the support of the Advisory Committee and shown below. Note: This is a draft set of priorities – a final set of priorities shall be reviewed by the Advisory Committee and confirmed by EOHHS.

Program	Priorities
Comprehensive AEs	• Integration and innovation in behavioral health care • Integration and innovation in SUD treatment • Integration and intervention in social determinants, including cross system impacts
Specialized Pilot LTSS AEs	• Developing programs and care coordination processes to enable people to reside safely in a community setting and to promote timely care transitions and reduced institutional/ED utilization • Home and Community based Behavioral Health capacity development for specialized adult day care, home care, and alternative living arrangements with capacity to serve members with behavioral health and/or dementia/Alzheimer's related service needs • Repurposing skilled nursing capacity for acute psychiatric transitions and/or adult day capacity

Consistent with these priorities and the requirements of the AE Certification Standards, Comprehensive AEs shall be required to demonstrate that at least 10% of Program Year 1 Incentive funds are allocated to partners who provide specialized services to support behavioral health care, substance abuse treatment and/or social determinants.

VI. Allowable Areas of Expenditure

Allowable uses of funds include the following three core areas and eight domains. Costs must be reasonable for services rendered.

EOHHS anticipates that some AEs incentives in Program Year 1 may be weighted toward development in core readiness domains 1-3 as set forth in the certification standards, as AEs build the capacity and tools required for effective system transformation. However, over time the allowable areas of expenditure will be required to shift toward system transformation capacities (domains 4-8). As such, in Program Year 1, allowable Readiness Expenditures (Category A, Domains 1 through 3 below), are limited as follows:

- Comprehensive AEs may devote no more than 30% of the total HSTP incentive pool to projects in the in the readiness category (Domains 1-3)
- Specialized AEs may devote no more than 60% of the total HSTP incentive pool to projects in the readiness category (Domains 1-3)

	Domains	Allowable Uses of Funds
A. Readiness	1. Breadth and Characteristics of Participating Providers	• Building provider base, population specific provider capacity, interdisciplinary partnerships, developing a defined affiliation with community based organizations (CBOs) • Developing full continuum of services, Integrated PH/BH, Social determinants
	2. Corporate Structure and Governance	• Establishing a distinct corporation, with interdisciplinary partners joined in a common enterprise
	3. Leadership and Management	• Establishing an initial management structure/staffing profile • Developing ability to manage care under Total Cost of Care (TCOC) arrangement with increased risk and responsibility
B. IT Infrastructure*	4. Data Analytic Capacity and Deployment	• Building core infrastructure: EHR capacity, patient registries, Current Care • Provider/care managers' access to information: Lookup capability, medication lists, shared messaging, referral management, alerts • Patient portal • Analytics for population segmentation, risk stratification, predictive modeling • Integrating analytic work with clinical care: Clinical decision support tools, early warning systems, dashboard, alerts • Staff development and training – individual/team drill downs re: conformance with accepted standards of care, deviations from best practice
C. System Transformation	5. Commitment to Population Health and System Transformation	• Developing an integrated strategic plan for population health that is population based, data driven, evidence based, client centered, recognizes Social Determinants of Health, team based, integrates BH, IDs risk factors • Healthcare workforce planning and programming
	6. Integrated Care Management	• Systematic process to ID patients for care management • Defined Coordinated Care Team, with specialized expertise and staff for distinct subpopulations • Individualized person-centered care plan for high risk members
	7. Member Engagement and Access	• Defined strategies to maximize effective member contact and engagement • Use of new technologies for member engagement, health status monitoring and health promotion
	8. Quality Management	• Defined quality assessment & improvement plan, overseen by quality committee

* The state may make direct investments in certain technology to support provider to provider EHR communication, such as dashboards and alerts. This investment would be made directly by the state with vendor(s) which would have the capacity and expertise to create and implement this technology in AEs statewide. This may be done in certain technology areas where direct purchasing by the state would result in significant efficiencies and cost savings. The products and tools resulting from this direct state technology investment would be made available to all AEs at no upfront charge. AEs would have the choice to either utilize the statewide tool at no charge or pay for their own tool. In this case, DSRIP funds would not be available for the AE to separately purchase such a tool.

Note that the allowable uses of funds specified above may not include any of the following expenditures:

- Alcoholic beverages
- Capital expenditures (unless approved in advance by EOHHS)
- Debt restructuring and bad debt
- Defense and prosecution of criminal and civil proceedings, and claims
- Donations and contributions
- Entertainment
- Fines and penalties
- Fund raising and investment management costs
- Goods or services for personal use
- Idle facilities and idle capacity
- Insurance and indemnification
- Interest expense
- Lobbying
- Marketing/member communication expense, unless approved in advance by EOHHS
- Memberships and subscription costs
- Patent costs

These non-allowable expenditures have been developed in alignment with Section 2 CFR 200 which outlines Financial Management and Internal Control Requirements for receipt, tracking and use of federal funds by non-Federal awardees, and shall be updated by EOHHS as appropriate.

VII. Required Performance Areas and Milestones

AEs must develop AE Specific Health System Transformation Project Plans. These plans shall specify the performance that would qualify an AE to earn incentive payments. The execution of an EOHHS qualified APM contract with the MCO shall be considered the first Performance Milestone of the HSTP Program, as shown below.

Earned funds shall be awarded by the MCO to the AE in accordance with the distribution by performance area defined in the AE specific Health System Transformation Plan, consistent with the requirements defined below:

Performance Area	Minimum Milestones	Program Year 1
Developmental Milestones	• Execution of an EOHHS qualified APM contract with the MCO, including performance milestones agreed upon by both parties • Detailed Health System Transformation Project Plan, including a specified set of Core Projects, and a proposed Infrastructure Development Budget by Project and Domain in accordance with state specified template • Quarterly Progress and Financial Reports in accordance with state defined template	75%

	• Developmental milestones MCO/AE Defined (at least 3 unique developmental milestones per Core Project per year)	
Value based purchasing metrics	• Demonstrated APM Progression, development of defined modeling capabilities to manage care under a TCOC approach • Marginal Risk Requirements • Minimum required share of marginal risk for which the AE is liable, in accordance with EOHHS define APM guidelines	5%
Outcome Metrics*	Comprehensive • Preventable Admissions • Readmissions • Avoidable ED Use • MCO/AE Specific Performance Targets Specialized • Total Cost of Care, inclusive of quality multiplier, in accordance with state defined APM requirements • Preventable Admissions • Readmissions • Completion of Advanced Directives	20%
Total		100%

*Note: For Program Year 1, at least 50% of the performance goals on outcome metrics shall be based on reporting only (for both Comprehensive and Specialized LTSS AEs).

The early milestones are intended to allow AEs to develop the foundational tools and human resources that will enable AEs to build core competencies and capacity. In accordance with EOHHS' agreement with CMS, participating AEs must fully meet milestones established in the AE specific Health System Transformation Project prior to payment. EOHHS recognizes the financial constraints of many participating AEs and that timely payment for the achievement of early milestones will be critical to program success.